DISSENTING VIEWS TO H.R. 4600

Introduction

The undersigned reject the legislation on medical malpractice adopted by the Committee. Not only has the majority gone beyond their purported goal of reducing medical malpractice premiums, they have done so in a manner that jeopardizes and penalizes the health and safety of consumers, particularly women, children, seniors, and the underprivileged.

We oppose this legislation for several reasons. First, medical malpractice is a serious problem in this country – causing an estimated one hundred thousand preventable deaths per year – and the legislation's severe restrictions will no doubt exacerbate this problem. There is also scant evidence that restricting victims' access to damages will have any appreciable impact on medical malpractice premiums, defensive medicine, or physicians' departure from the field. By unilaterally preempting state laws, this bill also raises serious constitutional issues, including Commerce Clause, due process and right to trial-by-jury issues.

We further oppose the legislation because the scope goes well beyond medical malpractice and goes so far as to limit the liability of HMOs for failure to provide coverage and to insulate drug and medical product manufactures from liability. Beyond this we have a number of specific concerns regarding the legislation's impact on victims, including draconian caps on non-economic and punitive damages that discriminate against women, seniors and children; a shortened statute of limitations; elimination of joint and several liability and the collateral source rule; the provision of periodic damages that will shift risk from wrongdoers to victims; and restrictions on contingency fees that will make it more difficult for the poorest members of society to obtain access to justice.

The following is a brief description of the bill and a more detailed itemization of our concerns.

Description of Legislation

H.R. 4600 limits the amount of non-economic damages–damages for pain and suffering–to $250,000.

In addition, H.R. 4600 eliminates joint and several liability, a longstanding common law doctrine that ensures that victims will be made whole. Similarly, the bill eliminates the collateral source doctrine, the effect of which is to shift the costs of malpractice from negligent defendants to innocent victims.

The bill dramatically limits a victim's ability to recover punitive damages in two distinct ways. First, the bill imposes a heightened standard for the recovery of punitive damages, requiring clear and convincing evidence that the defendant acted with malicious intent to injure

the plaintiff, or the defendant understood the plaintiff was substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury. It also limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater. The second category of punitive damages affected by the bill is with respect to manufacturers and distributors of drugs and medical devices. Specifically, the bill bans punitive damage liability for manufacturers of drugs and devices that are approved by the FDA. It also extends this immunity to the manufacturers of drugs and devices that are not FDA-approved but are "generally recognized as safe and effective," and to manufacturers or sellers of drugs from punitive damages for packaging or labeling defects. These restrictions are simply discriminatory and unjust.

H.R. 4600 also restricts the payment of a claimant's damage recovery to his or her attorney, and sets unprecedented limits on the amount an attorney may receive in contingency fee payments. Specifically, the total amount of all contingent fees for representing all claimants in a health care lawsuit may not exceed: (1) 40% of the first $50,000 recovered by the claimant(s); (2) 33 1/3% of the next $50,000 recovered by the claimant(s); (3) 25% of the next $500,000 recovered by the claimant(s); and (4) 15% of any amount by which the recovery by the claimant(s) is in excess of $600,000.

H.R. 4600 also provides an extremely restrictive statute of limitations for medical malpractice actions. It states that a "health care lawsuit may be commenced no later than 3 years after the date of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, *whichever occurs first*." (Emphasis added). This means that no lawsuit may be commenced after three years from the date of injury, regardless of the victim's knowledge of the injury.[1]

The bill also provides for periodic payments rather than a lump sum payments to victims. And finally, H.R. 4600 is not limited to medical malpractice actions but covers lawsuits for failure to cover against HMOs and other insurers as well.

I. Background

Medical malpractice is a tort-based legal claim for damages arising out of an injury caused by a health care provider. Tort claims are part of the "common law," or judge-made law, of the United States' civil justice system. Typically, tort claims have been reserved to the States.[2]

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[1] The only exception is for minors who have sustained injury before the age of 6. These victims may bring a lawsuit until the later of 3 years from the date of injury, or the date on which the minor attains the age 8.

[2] "Tort law at present is almost exclusively state law rather than federal law. . . ." *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (CRS Report 95-797 A), at 1.

The tort system provides a number of benefits to society. First, it compensates victims who have been injured by the negligent conduct of others. Second, it deters future misconduct and carelessness that may cause injury and punishes wrongdoers who inflict injury. Third, it prevents future injury by removing dangerous products and practices from the marketplace. Fourth, it informs an otherwise unknowing public of such harmful products or practices, thereby expanding public health and safety.[3]

Most medical malpractice claims are based on the tort of "negligence," defined as conduct "which falls below the standard established by law for the protection of others against unreasonable risk of harm."[4] In medical malpractice cases, this legal standard is based on the practices of the medical profession,[5] and is usually determined based on the testimony of expert witnesses.

As with other torts, remedies for medical malpractice may consist of compensatory damage awards for economic losses such as medical expenses or lost wages; non-economic losses such as pain and suffering, reduced life expectancy and diminished quality of life; and punitive damages to punish and deter willful and wanton conduct.

II. General Concerns

A review of the empirical evidence gathered over the last decade supports a number of conclusions: first, medical malpractice is a serious problem in the United States; second, H.R. 4600 does not respond to the problem of rampant medical malpractice and ignores the true reason for the "crisis" it purports to solve–the insurance industry's cycles and practices; and third, tort reforms have not reduced premiums for medical malpractice to any significant extent.

A. Medical malpractice is a serious problem.

Medical malpractice in the United States is a very real problem with devastating consequences. According to a study conducted in 1999 by the National Academy of Sciences Institute of Medicine ("IOM"), between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors.[6] This does not even include malpractice committed at outpatient

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[3] Joan Claybrook, *Consumers and Tort Law*, 34 Fed. B. News & J. 127 (1987).

[4] Restatement (Second) of Torts § 282 (1965).

[5] David M. Harney, Medical Malpractice § 21.2, at 413 (2d ed 1987).

[6] Kohn, Corrigan, Donaldson, Eds., *To Err is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999). Using the lower estimate, medical malpractice in hospitals is the 8th leading cause of death in this country; using the higher estimate, it is the 5th leading cause of death. *Id*.

centers, physician offices and clinics. These numbers are greater than the number of people who die due to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).[7]

Study after study has shown that the prevalence of medical malpractice extolls an enormous burden on its victims. A 1990 Harvard Medical Practice study found that medical negligence in New York hospitals results in 27,000 injuries and 7,000 deaths each year. The study found that eight times as many patients are injured by malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation.[8] At a 1992 meeting of the American Association for the Advancement of Science, it was reported that more than 1.3 million hospitalized Americans, or nearly 1 in 25, are injured annually by medical treatment; about 100,000 such patients, or 1 in 400, die each year as a direct result of such injuries.[9] In contrast to the low number of lawsuits that are filed on behalf of malpractice's victims, the total national cost of malpractice is quite high. The 1999 IOM study found that total national cost of medical malpractice (lost income, lost household production, disability and health care costs) is between $17 billion and $29 billion each year.[10]

B. H.R. 4600 does not respond to the problem of rampant medical malpractice and ignores the true cause of the "crisis"–the cyclical nature of the insurance industry and the investment practices of insurance companies.

Supporters of H.R. 4600 claim that insurance companies have become insolvent or have left certain markets because of excessive litigation and unrestrained jury awards. This so-called "crisis," however, mirrors the last insurance "crisis" that hit the United States in the mid-1980s and an earlier one in the mid-1970s. Similar to its predecessors, today's insurance "crisis" has less to do with the legal system, tort laws, lawyers or juries and more with the insurance underwriting cycle and insurance companies' own investment practices.

Insurance industry experts have articulated the cyclical nature of the industry, showing a boom and bust cycle of so-called "crises," beginning in the 1970s. During this first cycle, medical malpractice insurance premiums increased by large margins and certain specialties were denied

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[7] *Id.*

[8] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

[9] Christine Russell, *Human Error: Avoidable Mistakes Kill 100,000 Patients a Year*, Wash. Post Health Mag., Feb. 18, 1992; *see also* Harvey Wachsman, Lethal Medicine, The Epidemic of Medical Malpractice in America (1993).

[10] *See* Kohn *et al.*, *supra* note 6.

coverage.[11] As a result, all states but one initiated reforms designed to provide alternative sources of insurance and to reduce the number and costs of claims. Physician and hospital-owned insurance companies emerged as an alternative to traditional policy providers,[12] and, for at least a decade, insurance was accessible and affordable in a market dominated by these companies.

The mid-1980s saw another such "crisis." Prior to that, the insurance industry maintained affordable premiums and only minimal increases because of investments at high interest rates that produced significant yields. When interest rates dropped in 1984, driving down insurers' investment income, however, insurance providers responded with considerable increases in medical malpractice insurance premiums.[13] The mid-1980s saw insurance rate increases of 300% or more for manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance.[14]

As Joanne Doroshow testified at the hearing before the Subcommittee on Commercial and Administrative Law, what precipitates these crises is always the same. "Insurers make their money from investment income. During years of high interest rates and/or insurer profits, insurance companies engage in fierce competition for premiums dollars to invest for maximum return. More specifically, insurers engage in severe underpricing to insure very poor risks just to get premium dollars to invest. But when investment income decreases because interest rates drop, the stock market plummets and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a 'liability insurance crisis.'"[15]

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[11] U.S. Congress, Office of Technology Assessment, Pub. No. OTA-BP-H-119, Impact of Legal Reforms on Medical Malpractice Costs 13 (1993) [hereinafter OTA Report on Legal Reforms].

[12] Medical insurance providers consist of both stock and mutual insurance companies. The physician and hospital owned companies are among the mutual insurance companies created to provide the lowest possible premiums.

[13] *See* OTA Report on Legal Reforms at 15.

[14] Statement of Joanne Doroshow, before the House Subcommittee on Commercial and Administrative Law, June 1, 2002 [hereinafter Doroshow statement].

[15] *Id*. at 7. Another factor that may adversely affect insurance rates is the fact that since 1945 insurance companies have been exempt from the antitrust laws. *See* 15 U.S.C. §§ 1011-1015 (1945) (McCarran -Ferguson Act). Under the McCarran-Ferguson Act, courts have held that state regulation need not be meaningful or active in a particular instance to trigger the antitrust exemption. The result over the years has been uneven oversight of the insurance industry by the states, coupled with no possibility of federal antitrust enforcement, creating an environment

One insurance expert recently described today's situation:

> What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s and reaching a peak around 1997 and 1998, **insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses**. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income. Driven in large part by lobbyist for the insurance industry and doctors' groups, H.R. 4600 is the latest attempt to "fix" the system. Unfortunately, H.R. 4600 does not address the real problems, which include the quantity of malpractice being committed by the medical profession and the inability of many victims to obtain reasonable compensation.
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> In a perfect world, investment income would cover any deficiencies that might exist in underwriting results and the insurers' aggressive marketing and pricing strategy would prove to be successful. Alas, we do not live in a perfect insurance world and, as competition intensified, underwriting results deteriorated. Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.[16]

Thus, there are many factors, completely unrelated to jury verdicts and the civil justice system, that affect insurance rates, including the following: changes in state law and regulatory requirements; competitiveness within the insurance market; the types of policies issued within the industry; interest rates; state socio-economic factors, such as urbanization; national economic trends; and huge portfolio losses due to the falling stock market.[17] According to the National Association of Insurance Commissioners, these factors fall into three categories: (a) changes in interest rates, (b) underpricing in soft markets, and (c) adverse loss shocks that lead to supra-

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that has fostered a wide range of anticompetitive practices.

[16] Charles Klodkin, Gallagher Healthcare Insurance Services, *Medical Malpractice Insurance Trends? Chaos!*, Sept. 2001 (emphasis added).

[17] Numerous GAO studies and testimony over the past two decades have repeatedly demonstrated that the nexus between litigation, insurance rates, and health care costs is neither linear nor coextensive. *See, e.g.,* "Medical Malpractice: A Continuing Problem With Far-Reaching Implications," Statement of Charles A. Bowsher, Comptroller General of the United States Before the Subcommittee on Health House Committee on Ways and Means (GAO/T-HRD-90-24), Apr. 26, 1990.

competitive cycles.[18]

The current crisis has also been affected by two additional factors. First, September 11 accelerated the price increases that had already started to set in by providing the adverse shock loss component of the equation.[19] Second, St. Paul Insurance Company withdrew from the medical malpractice market, creating major supply and demand problems. Although St. Paul cited liability risks as the reason for its withdrawal, it is also noteworthy that St. Paul lost a significant amount of investment money in the Enron scandal.[20] In addition, St. Paul engaged in a premium price war in the 1990s, using the go-go stock market to cover the spread. Invested reserves grew so large that some of the funds were released to the bottom line as profit. When the stock market crashed, however, St. Paul was left with the option of exiting the market or increasing premiums.[21]

Astonishingly, given this history, H.R. 4600 addresses none of these problems. It does nothing about insurance companies' bad investment practices or the insurance companies' boom and busy cycles. Rather, as in every other cyclical insurance industry "crisis," the target and focus have been the legal system and restrictions on victims' rights to recover, respectively.

C. Empirical evidence shows tort reforms have not had a significant impact in reducing insurance premiums.

Supporters of H.R. 4600 argue that jury awards have skyrocketed, which in turn has caused malpractice premiums to increase, doctors to practice defensive medicine, and doctors to leave their practices in certain states with high premiums. They argue that restrictions on victims' abilities to pursue and collect on claims for malpractice will reduce these problems. A review of the empirical data indicates that the proponents' arguments are not correct and legal restrictions such as H.R. 4600 will not increase consumer welfare.

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[18] Cycles and Crises in Property/Casualty Insurance: Causes and Implications, edited by Cummings, Harrington and Klein, NAIC, 1991 at 339; *see also Risk Managers Blame Insurers for Renewal Woes*, National Underwriter, Jan. 14, 2002.

[19] Well before September 11, the Federal Reserve had cut interest rates several times, providing the first element, and insurers had been underpricing in the soft market, providing the second element. *See also Year in Review*, Business Insurance, Dec. 24, 2001 ("To be sure, the market began firming in 2000. But the Sept. 11 terrorist attacks sent insurance prices skyrocketing far beyond the estimates of increases that earlier were being attributed to a normal hard cycle.").

[20] Statement of Joanne Doroshow at 11-12.

[21] Todd Sloane, *Back on the tort reform merry-go-round*, 32 Modern Healthcare 28, July 15, 2002.

First, the empirical data shows that jury awards, particularly punitive damages, are not increasing at a rate far beyond the rate of inflation. According to the actuarial analysis of medical malpractice insurance conducted by J. Robert Hunter, Director of Insurance for the Consumer Federation of America,[22] the average malpractice payout has not changed much over the decade, hovering at approximately $30,000, not even taking into account inflation.[23] For the decade ending in December 2000, each closed claim for medical malpractice, including million dollar verdicts, averaged only $27,824.[24]

Supporters of H.R. 4600 cite anecdotal evidence that jury awards are increasing. One such study, conducted by Jury Verdict Research and released in March 2002, showed that jury awards in medical malpractice cases jumped 43% from 1999 to 2000. Studies such as this, however, are too narrowly focused to provide the complete picture. The JVR study cites data that is skewed toward the high-end and doesn't include defense verdicts (verdicts in which no money was awarded), verdicts in non-jury trials, verdict reductions by remittitur, or verdicts overturned on appeal. The JVR and similar studies are not adjusted for inflation and have no relation to what insurance companies actually pay out to claimants (an average of $30,000 per claim).[25]

As for punitive damages–damages that are designed to deter willful and wanton misconduct–the evidence shows that they are infrequent. According to the Bureau of Justice Statistics, in 1996 only 1.1 percent of medical malpractice plaintiffs who prevailed at trial were

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[22] *See* Letter from J. Robert Hunter to Joanne Doroshow, Oct. 13, 2001 and attached spreadsheet [hereinafter Hunter analysis]. To conduct this analysis, Mr. Hunter used the most recent insurance data available from the National Association of Insurance Commissioners and A.M. Best and Company. *Id*.

[23] *Id*.

[24] *Id*.

[25] Press Release, *Flawed Jury Data Masks Trends*, Center for Justice and Democracy, Mar. 23, 2002; *see also* Todd Sloane, *Back on the tort reform merry-go-round*, 32 Modern Healthcare 28, July 15, 2002 (JVR admitted that its 2,951-case malpractice database has large gaps in it–it collects award information sporadically and unsystematically, does not know how many it misses, cannot calculate the percentage change in the median for childbirth negligence cases, and excludes trial victories by doctors and hospitals that are worth zero dollars); Rachel Zimmerman and Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'–Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor–Delivering Ms. Kline's Baby*, The Wall Street Journal, A1, June 24, 2002 (discussing JVR's incomplete study).

awarded punitive damages and only 1.2 percent of those awards were awarded by juries.[26]

Second, medical malpractice premiums have not increased beyond the rate of inflation. The evidence compiled by Mr. Hunter shows that inflation-adjusted medical malpractice premiums have actually declined in the last decade. Average premiums per doctor barely climbed from $7,701 in 1991 to $7,843 in 2000, an increase of 1.9 percent. Adjusted for inflation, these figures show that premiums have actually decreased by 32.5 percent.[27] Equally importantly, the statistics show that medical malpractice legal costs constitute a small fraction of the of the cost of health care in the United States. Mr. Hunter's analysis supports the conclusion that the cost of medical malpractice at the national health care expenditure level is quite low: for every $100 of national heath care costs, medical malpractice insurance costs 66 cents. In the year 2000, the cost was 56 cents, the second lowest rate of the decade.[28]

Third, proponents' claims that doctors, fearing litigation, engage in the practice of defensive medicine simply do not bear out. In fact, the evidence shows that less than 8 percent of all diagnostic procedures are performed because of liability fears; most doctors who use aggressive diagnostic procedures do so because they believe the tests are medically indicated.[29] A study conducted by the non-partisan Office of Technology Assessment (OTA) found that "in the majority of clinical scenarios used in OTA's and other surveys, respondents did not report substantial levels of defensive medicine, even though the scenarios were specifically designed to elicit a defensive response."[30] The OTA further found that "[c]onventional tort reforms that tinker with the existing process for resolving malpractice claims while retaining the personal liability of the physician are [unlikely to] alter physician behavior."[31] Thus, the effects of H.R. 4600's limitations on defensive medicine are likely to be small. If anything, we are more likely to see the result of too little services.

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[26] *Tort Trials and Verdicts in Large Counties, 1996*, U.S. Department of Justice, Bureau of Justice Statistics, NCJ 179769 (August 2000), p. 7.

[27] Hunter analysis, *supra*.

[28] *Id*.

[29] U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, *OTA-H--602* (Washington, D.C.: U.S. Government Printing Office, July 1994) at 74.

[30] *Id*.

[31] *Id*. at 92.

Fourth, studies show that, despite claims by doctors' groups and the insurance industry,[32] doctors are not leaving certain fields because they cannot afford the insurance premiums. Data from the American Medical Association actually shows that there are 4.4% more physicians in patient care per 100,000 population in states without damage caps.[33] There are 5.8% more ob/gyn physicians per 100,000 women in states without caps.[34] And in states without malpractice limitations, there are 233 physicians per 100,000 residents, while in states with malpractice limitations, there are 223 physicians per 100,000 residents.[35]

Studies done on particular states bear out this evidence. For example, *Charleston Gazette* reporters Lawrence Messina and Martha Leonard's series "The Price of Practice"[36] found that, contrary to claims by the West Virginia Medical Association that doctors had left the state because of its lack of tort reform, the number of doctors in West Virginia had actually increased. In fact, between 1990 and 2000 the number of doctors had increased by 14.3 percent, a rate twenty times greater than the population.

The same is true in Pennsylvania. A census conducted by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that between 1990 and 2000, the number of doctors increased by 13.5 percent, while the population increased by only 3.4 percent.[37] Not only is Pennsylvania not losing doctors, it had more doctors in 2001 than it did in the preceding five to ten years.[38] Furthermore, the *Philadelphia Inquirer* notes that in 2000, "Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for every 100,000 residents in 2000, according to the American Medical

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[32] *See* Statement of the American Medical Association to the House Committee on Energy and Commerce, July 17, 2002, at 2-7; Statement of the National Medical Liability Reform Coalition, before the House Committee on Energy and Commerce, July 17, 2002, at 2.

[33] American Medical Association, *Physician Characteristics and Distribution in the US* (2001 ed).

[34] *Health Care State Rankings* (Morgan Quitno Press 2001).

[35] Senate Congressional Record, July 30, 2002, S7534.

[36] Martha Leonard, *State has seen sharp increase in number of doctors*, Sunday Gazette Mail, Feb. 25, 2001.

[37] Ann Wlazelek, *Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create 'hostile' climate*, Morning Call, Mar. 24, 2002; Josh Goldstein, *Recent census of doctors shows no flight from Pa.*, Philadelphia Inquirer, Oct. 2, 2001.

[38] Goldstein, *supra*.

Association."[39]

Fifth, there is no evidence to support the claim that restrictions on malpractice litigation will bring about appreciable health care savings. To date there is scant quantitative evidence that previous attempts at the state level have accomplished this purported goal.[40] In a comparison of states that enacted severe tort restrictions during the mid-1980s and those that resisted enacting any tort reform, no correlation was found between tort reform and insurance rates.[41] Indeed, some of the resisting states experienced low increases in insurance rates or loss costs relative to the national trends, while some states that enacted tort reforms experienced high rate or loss cost increases relative to the national trends. For example, data provided by Medical Liability Monitor in 2001 showed that in the practice of internal medicine, states with caps on damages had higher premiums than states without caps. For general surgeons, insurance premiums were 2.3% higher in states with caps on damages. And for ob/gyn's, premiums were only 3.3% lower in states with caps on damages.[42] On average, malpractice premiums were no higher in the 27 States that have no limitations on malpractice damages, than in the 23 States that do have such limits.[43] The vast majority of the evidence shows that tort reform does little if anything to reduce medical

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[39] Wlazelek, *supra*. Studies done on the ob/gyn market in New York yield similar conclusions. *See* New York Public Interest Research Group study, http://www.nypirg.org/health/malpractice_facts.html (N.Y. ranked 3rd in the nation in number of ob/gyn's per capita; the number of physicians in N.Y. has skyrocketed and increasing at a rate faster than the national average; N.Y. ranked 2nd in number of doctors per capita).

[40] It is hardly a foregone conclusion that such restrictions will "fix" the problem. In fact, both Republican and Democratic members of the Judiciary Committee requested the General Accounting Office to conduct an inquiry into the effect of state tort laws on medical professional liability premium increases nationwide.

[41] Robert J. Hunter and Joanne Doroshow, *Premium Deceit–the Failure of "Tort Reform" to Cut Insurance Prices*, Center for Justice & Democracy (1999).

[42] *Medical Liability Monitor* (Vol 26, #10–Oct 2001).

[43] Senate Congressional Record, July 30, 2002, S7534. Moreover, studies show that rising insurance rates have been a trend in the entire commercial industry, not just in the medical malpractice industry. Insurance prices have risen by 21% for small commercial accounts, by 32% for mid-size commercial accounts, and by 36% for large commercial accounts. Insurance for the construction industry, the commercial automobile industry, the property industry, the workers' compensation industry, and more, have all increased between 24% and 56%. *See* Council of Insurance Agents and Brokers, 4th Quarter 2001 Survey, released January 2002.

malpractice premiums.[44]

The California experience is perhaps the most telling of this fact. In 1975, California enacted into law the "Medical Injury Compensation Reform Act" (MICRA), after which many provisions of H.R. 4600 are modeled, including caps on non-economic damages, collateral source offsets, and limitations on attorneys' fees. Despite these "reforms," premiums for medical malpractice in California grew more quickly between 1991 and 2000 than in the nation (3.5% vs. 1.9%, respectively).[45] And between 1975 and 1993, California's health care costs rose 343%, almost double the rate of inflation.[46]

A comprehensive study of MICRA's impact conducted in 1995 found the following: per capita health care expenditures in California have exceeded the national average every year between 1975 and 1993 by an average of 9% per year; California's medical malpractice liability premiums actually increased by 190% in the twelve years following enactment of MICRA; hospital patient costs are higher in California than in other major states; and California's health care costs have continued to increase at a rate faster than inflation since the passage of MICRA.[47]

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[44] Insurance industry spokespersons practically admit this. As Sherman Joyce, president of the American Tort Reform Association (ATRA), stated, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." *Study Finds No Link Between Tort Reforms and Insurance Rates*, Liability Week, July 19, 1999. ATRA's General Counsel, Victor Schwartz, told *Business Insurance* that "many tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" Michael Prince, *Tort Reforms Don't Cut Liability Rates, Study Says*, Business Insurance, July 19, 1999. And Debra Ballen, the executive vice president of the American Insurance Association, stated that "insurers never promised that tort reform would achieve specific PREMIUM savings." Press Release, *AIA Cites Fatal Flaws in Critic's Reports on Tort Reform*, Mar. 13, 2002. Moreover, studies conducted by the National Association of Attorneys General and state commissions in New Mexico, Michigan and Pennsylvania confirmed that the crisis was caused not by the legal system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, MA: Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986).

[45] Hunter analysis, *supra*.

[46] Data provided by Consumers Union.

[47] *See* Proposition 103 Enforcement Project, *MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits*, 1995. Inflation rose 186% between 1975 and 1993. California's health care costs grew by 343% during the same period, and generally have grown at almost twice the rate of inflation since 1985.

Not only does the evidence show that California's tort reform has failed to lower premiums for doctors, it also shows that California's insurance companies are reaping excessive profits in the aftermath of tort reform. In 1997, California's insurers earned more than $763 million, yet paid out less than $300 million to claimants.[48] The National Association of Insurance Commissioners reported the following: malpractice insurance profits are ten times greater than the profits of other lines of insurance in California; the average profit for malpractice insurance in California was 25.40% of the collected premium; and less than half of medical malpractice premiums are paid to claimants–only 38.4% of medical malpractice premiums collected in California since 1988.[49]

III. H.R. 4600 Goes Beyond Medical Malpractice And Applies To Insulate HMO's Insurers, Drug Companies, And Manufacturers And Distributors Of Medical Devices.

Although H.R. 4600's proponents frequently tout it as a medical malpractice bill, its scope is far broader. In fact, the bill applies to (1) lawsuits against HMOs and other insurers, and (2) products liability claims against drug companies and manufacturers and distributors of medical devices.

A. H.R. 4600 completely preempts states' patients' bills of rights that have allowed HMOs to be sued for wrongful actions.

As currently drafted, this bill guts HMO reform laws the states have already passed. On pages 17 and 18, the bill defines a health care liability claim as "based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products."

We find it extremely problematic that legislation purporting to be a medical malpractice bill would be broad enough to cover lawsuits against HMO's and other insurers, particularly because such legislation serves to preempt the patients' bills of rights passed by some states. For example, the HMO law enacted in Texas under George W. Bush was Governor has a higher cap on punitive damages ($75,000) than H.R. 4600, and no caps on non-economic damages for suits against HMOs.[50] The Arizona law has no limits on damages for HMO lawsuits.[51] California, on

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[48] California Department of Insurance.

[49] National Association of Insurance Commissioners, Profitability By Line By State in 1997 (Dec. 1998).

[50] TX. Civ. Prac. & Rem. Code, Title 4, sec. 88.001 et seq. (1997).

[51] AZ Rev. Stat. 20-3153 et seq. (2000).

which much of H.R. 4600 is based, has no HMO caps.[52] Georgia's law does not allow any punitive damages but allows all non-economic damages against HMOs.[53] Maine's law does not allow punitive damages but has a higher cap on non-economic damages at $400,000.[54] And Oklahoma, Washington and West Virginia have no limitations on damages.[55] In one piece of legislation, H.R. 4600 completely eviscerates these protections specifically enacted by these states.

B. This "medical malpractice" bill also covers products liability lawsuits against manufacturers and distributors of medical devices and drugs.

The bill also exempts from liability for punitive damages manufacturers and distributors of medical devices, as well as pharmaceutical companies, who happen to obtain FDA approval. This provision provides a complete defense to liability for any drug or medical device that received pre-market approval from the FDA. In other words, if the FDA mistakenly allows a defective product on the market, the victims would not be able to sue at all. Even if both the manufacturer and the FDA have evidence of the dangers of a product, but permit it to be marketed anyway, the innocent, injured victim would be left without any opportunity for compensation whatsoever. We have seen no evidence that placing such faith in underfunded federal regulators is warranted.

Moreover, these federal regulators approve the design of the product before it enters the manufacturing process only; they does not approve the manufacturing of each batch of a product. Nevertheless, the manufacturer of a defective product is exempt from punitive damages under this bill. And the examples of products such as the Dalkon Shield, the Cooper-7 IUD device, high absorbency tampons linked to toxic shock syndrome, and silicone gel breast implants provide further reasons for our concerns. For each of these products, the manufacturer had information indicating the dangers posed by the product, and in each of those cases the sometimes lax approval process of the FDA allowed those deadly products to go to market.

IV. H.R. 4600 Raises Constitutional And Federalism Concerns

Among the many problems with H.R. 4600, we are also concerned that the bill may be unconstitutional under the Commerce Clause, the Fifth Amendment, and the Seventh Amendment.

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[52] CA Civil Code 3428 (1999).

[53] GA Code ann. 51-1-48 et seq. (1999).

[54] 24-A M.R.S.A. sec. 4313 (1999).

[55] OK. Stat. Title 36 sec. 6593 et seq. (2000); 48.43.545 Rev. Code WA (2000); 33-25C7 Code of W Va (2001).

First, the bill as drafted invites legal challenges to Congressional authority to legislate in this area, given the Supreme Court's recent Commerce Clause jurisprudence. There is a genuine issue as to whether H.R. 4600 constitutes a permissible exercise of Congress' power to regulate interstate commerce,[56] particularly to the extent the Act is applied to purely intrastate medical services. The Act itself contains no interstate commerce jurisdictional requirement, but merely makes a flat and unsubstantiated assertion that all of the activities it regulates affect interstate commerce.[57] Furthermore, the Supreme Court repeatedly has frowned upon federal intervention into areas like medical malpractice law that have been traditionally reserved to the states.[58]

The bill also invites challenges that it violates the Fifth Amendment, which provides that no person shall be "deprived of life, liberty, or property without due process of law,"[59] a proscription which has been held to include an equal protection component.[60] Plaintiffs will no doubt argue that the law does not provide a legislative *quid pro quo* and, as such, violates the Fifth Amendment. In exchange for depriving plaintiffs of their common law rights, the bill does not provide any offsetting legal benefits, at least to the parties directly harmed by the loss of their common law rights.

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[56] Article I, Section 8 of the Constitution provides, *inter alia,* "Congress shall have Power ... to regulate Commerce with foreign Nations and among the several States ... ." U.S. Const. art I, § 8, cl. 3.

[57] Section 2 of the bill states that "Congress find that the health care and insurance industries are industries affecting interstate commerce and the health care liability and litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high cost of health care and premiums for health care liability insurance purchased by health care system providers." According to the *Lopez* Court, one of the problems with the school gun ban was that it contained "no express jurisdictional element which might limit its reach to a discrete set of firearms possessions that additionally have an explicit connection with or effect on interstate commerce."

[58] The Court in *Lopez* observed that there were certain traditional areas of state law, such as criminal law and education, which should be off limits to federal intervention. The concurrence by Justices Kennedy and O'Connor also reasoned that the federal government should avoid involving itself in areas which fall within the "traditional concern of the states," noting that over 40 States had adopted laws outlawing the possession of firearms on or near school grounds.

[59] U.S. Const. amend. V.

[60] *See Bolling v. Sharpe*, 347 U.S. 497 (1954) (Fifth Amendment due process found to incorporate equal protection guarantees in case involving public school desegregation by the Federal Government in the District of Columbia).

Finally, the bill may violate the Seventh Amendment, which provides, "[i]n suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."[61] Because the bill eliminates the right of a jury to determine the appropriate amount of punitive and non-economic damages, this bill arguably deprives a plaintiff of the right to jury trial with respect to those elements of the case. These problems are highlighted by the fact that courts in some states that have enacted similar tort reforms, such as caps on non-economic damages and collateral source offsets, have ruled such reforms unconstitutional as violative of equal protection, due process, and the right to a trial by jury and access to courts.[62]

V. Specific Concerns

In addition to the general problems raised above concerning the overall purpose and effect of H.R. 4600, we have a number of specific concerns relating to particular provisions of the legislation. Most importantly, we are concerned that H.R. 4600 does not solve the alleged insurance and litigation crises but rather unjustly restricts a patient's right to recover for injuries inflicted by a negligent and careless health care provider. The following is an itemization of some of the most pressing problems adopted by the majority in passing H.R. 4600.

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[61] U.S. Const. amend. VII.

[62] Specifically, thirty-one states (AL, AZ, CA, CO, FL, GA, DE, IL, IN, KS, KY, LA, MO, NE, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, UT, WA, WI, WY) have ruled that such sweeping restrictions on the rights of medical malpractice victims are unconstitutional. Courts in twenty states (AL, CO, FL, GA, ID, IL, KS, NE, NH, ND, OH, PA, OK, OR, SC, SC, TX, UT, WA, WI) have ruled caps or limitations on medical malpractice damages to be unconstitutional. Courts in NH and PA have ruled that statutory limitations on attorneys fees in medical malpractice cases are unconstitutional, unfairly burdening medical malpractice victims and their lawyer, or resulting in an unconstitutional infringement on the right to jury trial. Courts in KS, NH, ND, OH, PA, and RI have ruled that medical malpractice statutes eliminating the common law "collateral source" rule are unconstitutional violations of due process and equal protection. Eighteen states (AZ, CA, CO, GA, IN, KY, LA, MO, NH, NM, NC, OH, OK, SD, TX, UT, WA, and WI) have held that their states' medical malpractice ultimate statutes of limitations are unconstitutional. Courts in four states (AZ, KS, NH, and OH) have ruled that structured settlement provisions of their states' medical malpractice statutes are unconstitutional violations of the right to jury trial, equal protection and due process. And courts in eighteen states (AZ, CA, CO, GA, IN, KY, LA, MO, NH, NM, NC, OH, OK, SD, TX, UT, WA, and WI) have ruled similar restrictions unconstitutional for failing to include adequate discovery provisions, for imposing restrictions which are too short in time, and for discriminating against minors or incompetent adults, in violation of equal protection, open courts, or due process guarantees, or the privileges and immunities clauses of state constitutions.

A. $250,000 aggregate cap on non-economic damages

We particularly object to the $250,000 cap on non-economic damages. Non-economic damages compensate victims for the human suffering they experience as the result of negligent conduct. Although intangible, these injuries are real and include infertility, permanent disability, disfigurement, pain and suffering, loss of a limb or other physical impairment. These damages are not accounted for in damages for lost wages, which are unrestricted under H.R. 4600.

We object to this cap for three reasons: it is manifestly unfair, it discriminates against women and children and those in low-economic brackets, and it does not take into account inflation.

First, the cap is unfair because it puts a price tag on the most horrendous of injuries and applies a "one-size-fits-all" philosophy that objectifies and erases the person and uniqueness of their suffering. An incident recited by Jamie Court during his testimony before the House Committee on Energy and Commerce,[63] illustrates H.R. 4600's manifest unfairness. Mr. Court told the story of Steve Olsen, a twelve year old from San Diego who is blind and brain damaged because of medical negligence. When he was two years old he fell on a stick in the woods. Steve's doctor gave Steve steroids and sent him home. Although his parents asked for a CAT scan, the doctor refused. The following day, Steve returned to the hospital in a coma because of the growing brain abscess he had developed, which would have been detected had the CAT scan been performed. At trial, the jury concluded that the doctor had committed medical malpractice and awarded $7.1 million in "non-economic" damages. One of the jurors later explained that they saw Steve as a boy doomed to a life of darkness, loneliness and pain. He would never play sports, work or enjoy normal relationships with his peers. He would have to endure a lifetime of treatment, therapy, prosthesis fitting and around-the-clock supervision. The judge, however, was forced the reduce that damage award to $250,000 because of the state's cap.

Mr. Court testified that he often visits Steve and his family when he is in San Diego. In 2001 he had 74 doctor visits, 164 physical and speech therapy appointments, and three trips to the emergency room. Steve's mother had to leave her job because caring for him is a full time job. He requires special education classes, for which Steve's mother must constantly fight. His pain and suffering is intangible but unrecognized by the misguided "reforms" that placed an arbitrary, one-size-fits-all cap on the amount he could recover.

Second, the $250,000 cap discriminates against women, children, seniors, and the poor. These categories of victims do not have high economic damages and are more likely to receive a greater percentage of their compensation in the form of non-economic damages. The result is that homemakers and children will be limited to $250,000 in non-economic damages, but CEO's could

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[63] Testimony of Jamie Court, before the House Committee on Energy and Commerce, July 17, 2002, at 4-6.

recover millions of dollars.[64]

Finally, the $250,000 cap is based on MICRA's cap, which was set in 1975 and has not been adjusted for inflation. A close look at California's numbers adjusted for inflation shows exactly what $250,000 is worth today. Using the consumer price index, the medical care value of $250,000 has dropped to just $40,389 over the 27 years since MICRA was enacted. One would need $1,547,461 in 2002 for the equivalent medical purchasing power of $250,000 in 1975.

This problem was acknowledged at the Judiciary's Committee's recent hearing by Rep. Berman, who was a member of the California Legislature when MICRA passed. In response to Mr. Gekas' concern that the recoverable costs of health care in California were still rising, Mr. Berman stated:

> I understand the gentleman's point, but the economic damages are about wages lost, about health care costs expended and incurred. Of course they're going to rise. Wages have risen since 1975; health care costs have risen since 1975. Why the notion–when you maintain a $250,000 cap that was appropriate in 1975, in 2002, you are decreasing the recovery for pain and suffering every single year by the cost-of-living. By any measurement, it is a decrease. To simply graft that figure onto here without making any compensation for 27 years of time, and without including some kind of cost-of-living factor for the future, is not maintaining the equilibrium of the California law at the time it passed. It's imposing a serious cut.[65]

Mr. Nadler elaborated on the problem. Pointing out the fact that we put cost-of-living adjustments in social security, pensions, congressional salaries, and federal salaries, he asks why this bill cannot have a cost-of-living, or inflation, adjustment. He states:

Unless you want to say that what you really want to do is say no economic damages

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[64] In their 1995 article, Thomas Koenig and Michael Rustad studied the effects of tort reforms on the different genders, finding that women are disproportionately affected by such reforms. Thomas Koenig and Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 Wash. L. Rev. 1 (1995). Specifically, the study found that women receive smaller economic verdicts for equivalent injuries because of lower overall wages. *Id*. at 78. And medical malpractice awards to women were almost three times more likely to include a pain and suffering component as those given to men. *Id*. at 84. This is true because women are most likely to suffer severe non-economic loss (loss of fertility, disfigurement, etc.) and be the victims of the types of medical malpractice that lead to punitive damages (sexual assault, fraud, false imprisonment, and extreme violation of medical standards, etc.).

[65] The Help Efficient, Accessible, Low-Cost, Timely Health Care Act: Hearings before the House Comm. On the Judiciary, 107th Cong. 2d Sess (Sept. 10, 2002) [hereinafter "2002 Medical Malpractice Hearing"], Transcript at 21-22.

eventually, because that's what this does. It reduces it to insignificance, ultimately.

> It seems to me that any hard-dollar amount in legislation has to have an inflation factor in it. And if you don't put that in what you're really saying, and maybe that's the will of the Republicans, that we don't want people to get compensation for noneconomic damages. We don't dare say it, but that's what we want. So we set up an amount that was appropriate in 1975 and by 2000, it's inadequate, and by 2025, no one will even care about it anymore, because it's a pittance.[66]

As Mr. Nadler accurately summarized, the $250,000 cap is "unfair. It's unjust. And frankly, it's totally indefensible not to have an inflation factor in a limit like this."[67]

B. Abolition of joint and several liability

In addition, we oppose H.R. 4600's total elimination of joint and several liability from medical malpractice cases because the result is to shift responsibility from the wrongdoer to the innocent victims of medical malpractice. Joint and several liability has been a part of the American common law for centuries. The doctrine provides that all tortfeasors who are responsible for an injury are "jointly and severally" liable for the claimant's damages. This means the victim can sue all responsible defendants and recover from each one in proportion to that defendant's degree of fault, or sue any one defendant and recover the total amount of damages. A defendant who pays more than its share is then entitled, under the doctrine of contribution, to seek compensation from other responsible parties based on their degree of fault.[68] The doctrine is designed to help ensure that victims of wrongful conduct are able to fully recover damages for their injuries, especially when one or more of the defendants is judgment-proof.[69]

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[66] *Id*. at 23-24.

[67] *Id*. at 24. (The amendment prompting this debate proposed that Section 4, providing for caps on non-economic damages, be struck. The amendment almost passed, receiving a 14-14 vote.)

[68] Restatement (Third) of Torts § 23 (1999).

[69] At the hearing, Mr. Chairman stated the crux of the issue when, after acknowledging that the rule is "motivated by a desire to ensure that plaintiffs are made whole," he said: "The HEALTH Act, by providing a fair share rule, it apportions damages in proportion to a defendant's degree of fault and prevents unjust situations in which hospitals can be forced to pay for all damages for an injury, even when the hospital is minimally at fault." 2002 Medical Malpractice Hearing, Transcript at 16. As we see it, if one has to choose between protecting victims of malpractice or protecting hospitals who every so often may not receive contribution from the other wrongdoers, the choice is obvious. As Mr. Scott put it, "which is more fair? For the hospital to decide to apportion all of that amonst itself, which is all insured anyway? Or have

The majority's reasons for eliminating the doctrine in medical malpractice cases is nothing but an extreme reaction to mostly unsubstantiated anecdotal stories, rather than a moderate response to the facts. Mr. Bachus's hypothetical of a drug dealer who gets shot during a drug deal gone bad, who then goes to the hospital and receives treatment from a doctor who is fatigued, is a perfect example. Mr. Bachus raises the possibility that the drug dealer will be found to be 99 percent at fault and the hospital one percent at fault, but the drug dealer recovers 100 percent because of joint and several liability.[70] As Mr. Frank correctly points out, "a drug dealer who was shot and was 99 percent responsible and recovered . . . is the sort of example that makes no constructive contribution to the debate."[71]

These preposterous hypotheticals are the basis for the majority's extreme response–the elimination of the doctrine altogether–even though far more moderate responses previously have been propounded. For example, in 1999 the Congress passed the Y2K bill, which had several limitations on the total abolition of joint and several liability. First, it had a complete carve-out where the defendant acted with specific intent to injure the plaintiff or knowingly committed fraud.[72] In addition, the Y2K Act provides that if portions of the plaintiff's damage claim ultimately prove to be uncollectible, and the plaintiff is an individual with a net worth of less than $200,000 and damages are greater than 10 percent of a plaintiff's net worth, a solvent defendant is responsible for paying an additional 100 percent share of the liability, or an additional 150 percent of this amount if it acted with "reckless disregard for the likelihood that its acts would cause injury."[73]

C. Limits on punitive damages in medical malpractice cases

The limitations on punitive damages are also of major concern to us for two reasons: the heightened standard is practically impossible for plaintiffs to prove, and the $250,000 cap is inadequate in extreme cases of abuse, such as those involving rape or drugs.

First, the heightened standard for recovery–the requirement of clear and convincing evidence that the defendant acted with malicious intent to injure (or he was substantially certain

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the plaintiff have that possibility and lose 1 percent there because they couldn't find that one, or 2 percent there, and they collect all from this one and a little bit–this one goes bankrupt? Which is more fair? You've got somebody with a $100,00 judgment and 50 people, possibly, at fault." *Id.* at 31.

[70] *Id.* at 28.

[71] *Id.* at 34.

[72] 15 U.S.C. § 6605(c).

[73] *Id.* § 6605(d).

the plaintiff would suffer injury but failed to avoid such injury)–is so extreme it is practically criminal. This standard makes it almost impossible for plaintiffs who have been egregiously wronged to recover punitive damages.

Second, even plaintiffs who could meet this standard are still limited by the cap at $250,000 or two times the amount of economic damages. This cap completely eviscerates the deterrent effect punitive damages have on egregious misconduct of defendants because the threat of having to pay a maximum of $250,000 would not affect many large companies or wealthy individuals. Moreover, the cap applies no matter what the conduct, even in situations where a medical professional harmed a patient because he was under the influence of alcohol or drugs, or where a doctor sexually assaults his patient.[74]

D. Elimination of punitive damages for products approved by the FDA.

In addition to the caps on punitive damages, we are especially troubled by the bill's abolition of punitive damages for products that have been approved by the FDA. Simply because a product has been approved by the FDA does not mean the company should be immunized from punitive liability when the product, despite such approval, causes severe harm to an individual. This is especially compelling given that studies have shown that medical devices cause approximately 53 deaths and over 1,000 serious injuries annually, costing approximately $26 billion annually.[75] Government safety standards, at their best, establish only a minimum level of

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[74] In fact, a report by Public Citizen found that "47.7% of doctors [found to have been disciplined for sexual abuse or misconduct by a disciplinary board] were allowed to continue practicing, their behavior probably unknown to most if not all of their patients." Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, D.C. (2000).

[75] A recent article by Robert Cohen and J. Scott Orr sets out startling statistics with respect to the medical implant industry. A few are as follows:

- During the past 10 years, 573 recall notices covering more than 2 million implants were issued for lapses such as mislabeling, structural failure, or manufacturing error. All but one of these errors were noticed by manufacturers, not the FDA.
- Of the 3500 proposed medical devices reviewed by the FDA last year, 98% were approved under an expedited process that requires no clinical testing.
- Federal law requires the FDA to inspect medical device manufacturers every two years, but due to budget constraints, it actually visits U.S. plants on average every five years and overseas plants ever 13 years.

See Robert Cohen and J. Scott Orr, *Faulty Medical Implants Enter Market Through Flawed*

protection for the public. At their worst, they can be outdated, under-protective, or under-enforced.

Moreover, the bill completely insulates manufacturers and distributors of products and drugs from defects arising during the manufacturing process, which occurs after the FDA has given its approval of the device.

And finally, banning punitive damages for FDA-approved products will have a disproportionate impact on women and seniors, who make up the largest class of victims of medical products. There are many examples of FDA-approved products that are dangerous and have caused harm to scores of women, including DES, the Dalkon Shield and Copper-7 IUDs, super-absorbent tampons, high-estrogen oral contraceptives, and the weight loss drug phen-fen. For each of these products, the manufacturer had information indicating the dangers posed by the product.[76]

E. Repeal of the collateral source rule

We dissent from the bill's repeal of the collateral source rule because the effect is also to shift the costs of malpractice from negligent defendants to innocent victims. The collateral source rule prevents a wrongdoer from reducing the amount of damages it must pay a victim by the amount the victim receives from outside sources. Payments from outside sources often include health or disability insurance, for which the victim already paid premiums and taxes. The rule is fair because the doctrine of subrogation, which provides that the collateral source has the right to reimbursement from the victim out of the damage award, ensures that no source pays more than its share of the liability.[77]

In addition to shifting costs to the plaintiff, eliminating the collateral source rule would discourage prudent insurance planning by penalizing consumers for acting responsibly[78]; would undermine the deterrent effect of the malpractice system by enabling negligent physicians to avoid

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System, Newhouse News Service, 2002.

[76] *See also* Koenig and Rustad, *supra*, at 38-46 ("There are far too many examples of instances where the FDA could not by itself adequately protect the public from dangerous, defective medical devices") (citing Lack of Life Saving Medical Devices, Hearing on S. 687 Before the Subcomm. on Reg. and Gov't Info. Comm. of the Senate Comm. on Gov't Affairs, 103d Cong., 2d Sess. (testimony of Kristin Rand, counsel on behalf of Consumer's Union)).

[77] *See* Kenneth Abraham, Distributing Risk: Insurance, Legal Theory, and Public Policy, 1330-172 (1986); Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 Cal. L. Rev. 1478, 1481-85 (1966).

[78] *See* James L. Branton, *The Collateral Source Rule*, 18 St. Mary's L.J. 883 (1987).

liability for damages they inflict[79]; and could result in a double reduction of the victim's damages, by the defendant and by subrogation.

F. Contingency fee limitations

In addition, we disagree with the provision in the bill limiting contingency fees for attorneys. Contingency fee arrangements can serve a useful and essential function in the legal system. They allow injured customers who could not otherwise afford legal representation access to the courts because the attorney agrees to take the case on behalf of an injured patient without obtaining any money up front from the client. The attorney thus incurs a risk in taking on the case because if the client loses, the attorney never gets paid. Not only does this help ensure that poor victims have access to the civil justice system, it also serves as a screening mechanism for unmeritorious cases on which attorneys will not take a risk.

H.R. 4600's restrictions make it more difficult for poor victims of medical malpractice with legitimate claims to find legal representation. Moreover, it is unfair to restrict plaintiffs' attorneys fees but not defendants, especially when defense attorneys are usually paid by the hour and thus have incentive to engage in meaningless litigation to drive up the costs.[80]

G. Periodic payments

As with the other provisions of the bill, the provision regarding periodic payments harms victims and protects wrongdoers. First, it allows the negligent party or insurance company to invest and earn interest on the victim's compensation. Second, it puts the onus on the victim, not the wrongdoer, to pursue the compensation in the event that the wrongdoer files for bankruptcy or refuses to pay. And if the wrongdoer files for bankruptcy, the chances of the victim ever receiving compensation for his or her loss is close to nothing. Finally, it leaves the victim without adequate resources in the event of an unanticipated medical emergency, if costs of the victims's medical care increase beyond his or her means, or a special medical technology is made available which the victim requires. In these circumstances, the injured patient would have to retain a lawyer to have the schedule modified.

H. Reduced statute of limitations

Finally, we oppose this statute of limitations for several reasons. The most important is

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[79] *See* Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 Law & Contemp. Probs. 57, 72 (Spring 1986).

[80] We also find it interesting that the majority would support a bill that is so anti-capitalistic. Restrictions on contingency fees are restrictions on compensation to attorneys who have worked hard and performed in the maketplace. This provision could not be more "anti-Republican."

that it cuts off all meritorious claims involving diseases with long incubation periods. For example, HIV often goes undetected for eight to ten years. Under H.R. 4600 a patient who contracted HIV through a negligent blood transfusion, but did not learn of the disease until after three years from the date of the transfusion, would be barred from filing a claim. Other examples include cases in which doctors have left foreign objects inside patients' bodies during surgery. Or cases where a patient takes a newly developed drug prescribed by his or her dermatologist, only to learn four years later that the drug caused heart damage. Or cases where a patient's pacemaker, implanted with a defect five years earlier, fails. In each of these cases, the injury would not be discovered until the statute of limitations under H.R. 4600 had come and gone.

Real life examples are abundant. One involves a young girl named Collazo, who was eight years old when she sought treatment at the hospital for an ankle injury. She was examined but not treated and told to return two days later. When she returned, her ankle was severely flexed downward. The hospital placed a splint on her ankle and sent her home, advising her to see a private physician. By the time a private physician diagnosed her (with three severed tendons), her only treatment option was tendon grafting. She suffered significant lost range of motion on her foot, she cannot extend her toes upward, she has a limp, cannot engage in athletics, and can only wear sneakers. Under the state's ten year statute of limitations, Collazo filed a lawsuit and received $1.2 million from the jury, mostly for noneconomic loss.[81] Under H.R. 4600, however, Collazo would have been prohibited from even filing the lawsuit–she was eight years old when the injury occurred, placing her outside the minority exemption, and requiring her to file the lawsuit by the time she was nine to preserve her rights.[82]

Conclusion

Collectively, the supposed "reform" included in H.R. 4600 would severely limit victims' ability to recover compensation for damages caused by medical negligence, defective products, and

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[81] *See Collazo v. New York City Health & Hosps. Corp.*, N.Y. Bronx County Sup. Ct., No. 8606/94 (1999).

[82] It is useful to note that H.R. 4600's statute of limitations is more restrictive than statutes of limitations provided for by most states. Most states allow plaintiffs two years from the date of injury to sue for medical malpractice. And many states afford plaintiffs a discovery rule, which tolls the statute of limitations until the plaintiff knew or should have discovered the injury. For example, Arizona allows plaintiffs to file a lawsuit up to two years from "reasonable discovery." *See* Az. Rev. Stat. Ann. § 12-542(1). D.C. provides that the time for filing runs from the date the plaintiff should have known of the injury. *See Stager v. Schneider*, 494 A.2d 1307 (1985). Indiana allows two years from the date of reasonable discovery. *See* In. Code § 34-18-7-1(b). There are many more examples of states that do not arbitrarily limit a victims' ability to bring a lawsuit for injuries he or she has sustained as a result of medical negligence but could not reasonably discover for more than three years. By contrast, while H.R. 4600 allows plaintiffs three years to discover the injury, any reasonable discovery after three years is simply too late.

irresponsible insurance providers. In addition to raising core issues of fairness, the legislation would intrude into an area which has traditionally been the sole province of the states, many of which have enacted their own medical malpractice legislation in recent years. H.R. 4600, which is designed to limit medical malpractice premiums and jury awards, presents a "fix" that is not supported by the empirical evidence; indeed it is being propounded at a time when the great wealth of data suggests that there is no medical malpractice "crisis" in our society. For these and other reasons set forth above, we strongly believe H.R. 4600 should be rejected.

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